Testimony of the
Connecticut ENT Society
Connecticut Urology Society
Connecticut Orthopaedic Society
Connecticut Society of Eye Physicians
Connecticut State Society of Anesthesiology
Connecticut Chapter of the American College of Surgeons
Connecticut Chapter of The American College of Cardiology
Connecticut Dermatology and Dermatologic Surgery Society

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On S.B. No. 258 An Act Concerning Appeals of Health Insurance Benefits Denials.
Before the Insurance and Real Estate Committee
On
March 4, 2010

Good Afternoon, Senator Crisco, Representative Fontana and other distinguished members of the Insurance and Real Estate Committee, my name is Dr. Bill Ehlers, and I am a board certified ophthalmologist and am the legislative chairman of the CT Society of Eye Physicians. I am here as a representative to over 2500 physicians in the medical fields of Ophthalmology, Otolaryngology, Dermatology, Orthopedics, General Surgery, Anesthesiology, Cardiology and Urology to support SB 258.

I am here to applaud the efforts of this committee for continuing to raise legislation which will further advance patient care by improving the appeals process when claims are denied. For several years now we have been supporting various pieces of legislation that attempt to improve the external appeals process in Connecticut for our patients. In 2007, we testified in support of HB7055, An Act Concerning Medical Necessity and External Appeals which passed and became Public Act 07-75 and helped to define medical necessity.

SB 258 is an excellent bill that places patient care first, and appropriately places the onus on the insurer to demonstrate why a properly submitted claim has been denied. It also helps patients by requiring insurers to cover medications while they are under appeal. One of my colleagues described the anguish of his patient with glaucoma, who was required to use a generic drug. The patient felt that she was having intolerable side effects from the drug, and the ophthalmologist wrote a prescription stating that the brand name eye drop was medically necessary. Still, the insurer denied it. The doctor then wrote a letter of appeal; it too was denied. The patient was afraid to use the generic and could not afford the brand name drug; therefore she went several days without treatment, until she could get to her ophthalmologist who gave her a sample bottle. This bill should put an end to this type of unfortunate event.

We do believe, however, that this bill could be strengthened for patients and providers if the filing requirements were altered to allow providers to file multiple claims, for both primary and secondary claims, under a single twenty-five dollar filing fee, as long as they had identical service and diagnostic codes. It is costly in both time and administrative overhead for healthcare providers to file individual appeals when a pattern of denial is noted from a managed care organization. In fact, we discovered this very situation in 2005 when Aetna suddenly began to routinely issue denials for all claims for the use of scanning laser ophthalmoscopy – a technology that has become the standard of care for patients with glaucoma and retinal

disease. In 2005, this technology was revolutionizing the diagnosis and treatment of patients with these serious, sight threatening conditions, and Aetna and other insurers had been paying for these tests for several years. Suddenly and without warning or explanation, Aetna rejected all claims for these studies as "experimental and not medically necessary". Other insurers continued to pay for these services, but thousands of appeals had to be filed before Aetna ultimately reversed this policy.

It is a financial burden for providers to pay individual filing fees when the issue involved is the same for a series of appeals. Efficiency must be a goal in all areas of health care if we are to control costs, and if providers are allowed to submit multiple identical appeals with one filing fee it would be more efficient for them and for the outside review company hired by the state to review these appeals. This approach would also save the state money, something that is more critical than ever, as in the past we were informed by the Insurance Department that each external appeal cost Connecticut roughly five hundred dollars. One can only guess what the current cost per claim actually is, but it is likely much higher now.

In closing, we would like to thank this committee for considering SB258 and if there are any questions about our proposed amendments which we believe would help strengthen this bill I can answer them.